

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032843

STATE FILE NUMBER

318

1003

8528

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED SEP 10 1962

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis,</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis,</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4430 1/2 So. 38th Str.</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4430 1/2 So. 38th Str.</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LEWIS A. RITTER</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>4th,</b> Year <b>1962</b>			5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>			8. DATE OF BIRTH <b>12-15-1900</b>			9. AGE (last birthday) <b>61</b>			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>			11. BIRTHPLACE (City and state or country) <b>Bloomfield, W. Virginia</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Lewis Ritter</b>			13b. MOTHER'S MAIDEN NAME <b>Ann Mokray</b>			14. NAME OF HUSBAND OR WIFE <b>Olivia Ritter</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Olivia Ritter-4430 1/2 So. 38th Str.</b>			18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Transitional cell Carcinoma</b> DUE TO (c) <b>Metastasis Lung. Urinary Bladder</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>cachexia</b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION <b>St. Louis,</b>			COUNTY <b>Missouri.</b> STATE		
21. I attended the deceased from <b>Nov 7, 1961</b> to <b>present</b> and last saw him alive on <b>Aug 23, 1962</b> Death occurred at <b>8:00 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			22a. SIGNATURE <b>Mary Schallert MD</b> (Degree or title)			22b. ADDRESS <b>539 No. Grand Ave</b>			22c. DATE SIGNED <b>Sept 4, 1962</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>			23b. DATE <b>Sept. 6, 1962</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Missouri Crematory</b>			23d. LOCATION (City, town, or county) <b>St. Louis, Missouri.</b>		
24. FUNERAL DIRECTOR <b>Kriegshauser-4228 S. Kingshighway Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>SEP 5 1962</b>			26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>					

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

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Rev. 4/59

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Dr. Schuttgen  
17975 Avenue  
Humboldt Bay

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Ernest W. Spillars

Licensed Embalmer No. 4080

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.